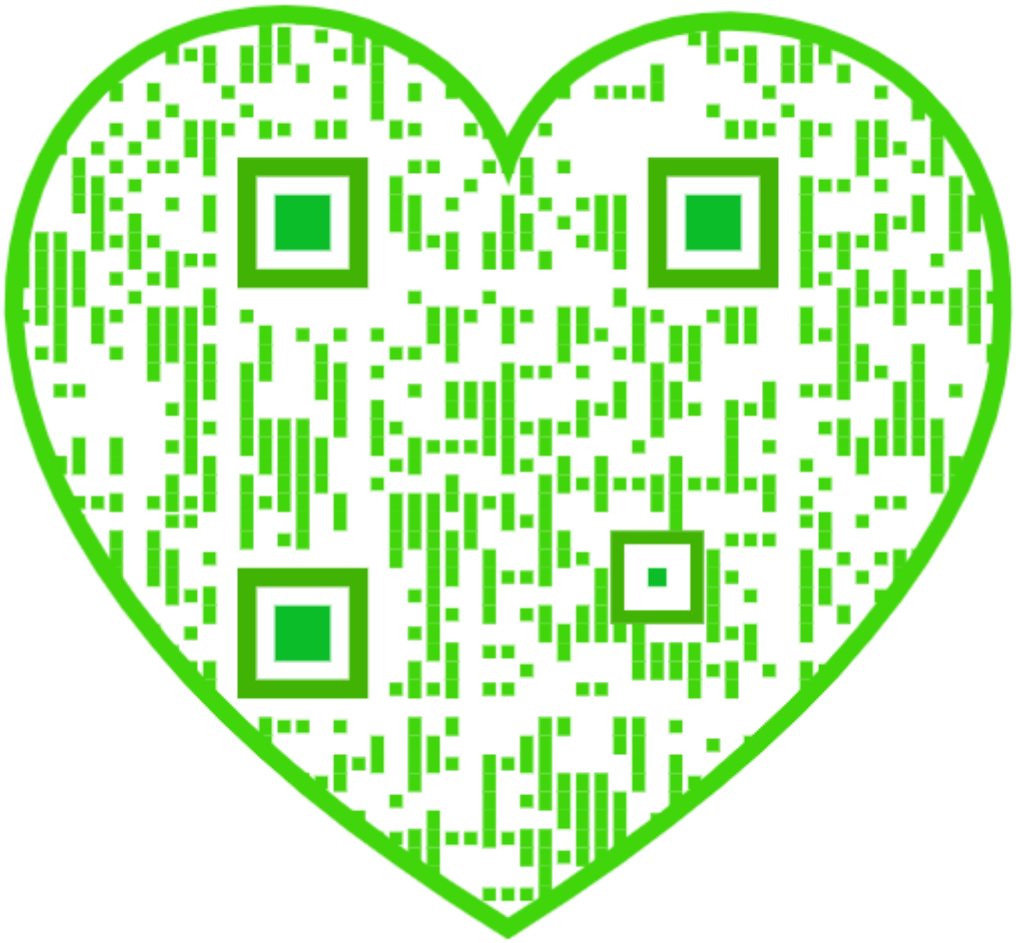
Exercises in Differential Diagnosis

1902



J. Dellinger Barney
34 Perrin Street
Roxbury
Mass.
Harvard Medical School '04

Paratyphoid Pathology
Journ. of Inf. Diseases. Nov 1/04.

EXERCISES

IN

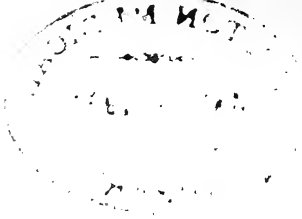
DIFFERENTIAL DIAGNOSIS.

ARRANGED BY

RICHARD C. CABOT, M. D.

BOSTON:
THOMAS GROOM & CO.
1902.

Copyrighted, 1902,
By Richard C. Cabot.



7045

BOSTON MEDICAL
MAY 8 1908
LIBRARY.

An old washerwoman, sixty-eight years old, generally healthy, has been feeling poorly for a month and losing appetite. A week ago began to have pain in abdomen; at first all over, but later settling in the lower left corner. Hurts her especially if she tries to walk, but has not been severe enough to keep her awake until last night, when it became severe. She has always been constipated, and the bowels have not moved for two days. No vomiting, but has taken hardly anything to eat for two days.

Examination: Emaciated, sallow, tongue coated, breath offensive. Temporal arteries stiff and tortuous. Heart dulness reaches to the right border of the sternum and as high as the second rib. Apex just below the fifth rib in the nipple line. At the ensiform cartilage, a short murmur replacing the second heart sound and heard less distinctly elsewhere. First sound at the apex very short; heart's action somewhat irregular. Few moist rales at bases of both lungs, with slight dulness and diminished breathing over lower half of left back. Voice sounds normal. Tactile fremitus slightly diminished. Abdomen slightly distended; tender in left iliac fossa, where a deep resistance is felt, but no tumor to be outlined. Liver dulness from seventh rib to rib margin. Right kidney palpable. Urine normal color; acid, 1017; trace of albumen.

Sediment: considerable pus, squamous, spindle and neck of bladder cells. Calcic oxalate crystals and mucus. Knee jerks not obtained. Temperature, 102 at entrance; normal next day. Pulse, 100. An enema brought away a small movement, very dark in color.

Diagnosis? Prognosis? Treatment?

What probably explains the area of liver dulness?

How is the temperature explained?

What is the significance of the calcic oxalate?

Called to see a young girl of twenty-one, single, who is said to have had, twelve hours before, a large pulmonary hemorrhage, — a pint, after a few days' cough. Previously well, but nervous; easily startled and frequently troubled with food "going the wrong way" and causing symptoms of temporary spasm of the glottis.

When seen, could only speak in a whisper; throat examination was impossible on account of gagging. Lungs entirely negative, except slight dulness and prolonged expiration at right apex. Heart somewhat rapid; systolic murmur at base of the heart, loudest in pulmonary area. At the root of the neck, in front, a swelling size of a hen's egg, smooth, soft, not tender. Abdomen negative. Face very pale, lips less so. Slight oedema of ankles.

Urine: pale; acid, 1018; albumen, slightest possible trace; 1 per cent. of sugar; amount, 2½ quarts. Sediment, mostly squamous and neck of bladder cells. Few small hyaline casts.

Blood: reds, 4,800,000; whites, 10,000; Hb., 60 per cent.

Diagnosis? Prognosis? Treatment?

A bank president, seventy-four years old, of large frame, lost his father at sixty-four from apoplexy, his mother at about the same age from phthisis. Several of his sisters also died of phthisis. His health has been exceptionally good, and a daughter cannot remember his having taken to his bed before. During the past year his weight has gradually fallen from 240 to perhaps 190 pounds. His color has been poor occasionally, and it has been noticed that a sudden pull on the part of his horses while driving would make him cry out, "Oh! my stomach!" He has not been able to walk as much as formerly on account of pain in the back and dyspnoea. He has also had sleepy turns, even after breakfast, for a year or more. About four weeks ago, walking up a slight incline after a concert, he lost his breath and had to stop six times on his way home, even after he reached level ground. December 25 he sent for his physician for a "catarrhal cold." The pulse was 38, regular, the temperature subnormal; there was some oedema and eczema of the legs, and moist rales over the base of both lungs, without notable dulness or change in the quality of the respiratory murmur. He stayed indoors and three days later took to his bed. Very soon after this he had frothy, profuse and thin, pink expectoration, with somewhat labored but not quickened respiration. The slow pulse persisted. The urine was about a quart in twenty-four hours, normal in specific gravity, with hyaline and finely granular casts.

January 13 he was seen in consultation. His chief complaint was of weakness and anorexia. Digestion fair, bowels regular; practically no cough or expectoration. Most of the time is passed in sleep. He lies by preference on the right side, with the head low. He looks less than his age; the lips are slightly cyanotic, the respiration easy, the tongue moist and clean, the mind clear when awake. The pulse is 38, regular, synchronous with the apex beat. During the last fortnight it has never been found above 40, and has been counted at 24. The radial arteries are slightly degenerated. The cardiac impulse is in the fifth space, nearly an inch beyond the left nipple; dulness seems rather increased to the right. Systolic murmurs are heard in both the aortic and mitral areas and the second sound is reduplicated at the apex. The lungs are clear. There is dulness below the right costal border, but palpation gives negative results in that region. Beyond slight oedema of the feet, physical examination is otherwise practically negative.

Diagnosis? Prognosis? Treatment?

A boy, fourteen years old, of gouty family history, complains for a year of frontal headache, not very severe but persistent and wearing. Appetite excellent, but digestion not as good as it has been. Has grown suddenly very irritable, having been previously sweet-tempered. He has lost flesh during the year and seems listless and weak. Sleeps well. Bowels somewhat costive. Getting pale. Heart, lungs and abdomen negative. Knee jerks not easily obtained, but gait shows only weakness. Urine normal color, acid 1028, no albumen. Sediment negative. Temperature 98, pulse 96. No oedema. Blood negative.

Diagnosis? Prognosis? Treatment?

A lady, forty years old, has a "cold" for some days, then becomes rapidly worse, with chilly feelings but no distinct rigor; pain about right side, persistent cough and thick, greenish expectoration. Pulse 120, temperature 102 to 103 degrees. Tongue dry. After a few days, dulness is found in the upper part of the right chest, back and front, with bronchial breathing and subcrepitant rales. Somewhat later, the whole upper right back becomes dull and bronchial breathing is heard over the upper two-thirds. There is some subcrepitus. Expectoration never bloody.

In convalescence, the dulness disappears slowly from above downward, outlasting the bronchial breathing some weeks.

Diagnosis? Prognosis? Treatment.

A lawyer, aged sixty-eight, has always worked hard, and for the past three years had great anxieties and no vacation. He had typhoid fever twenty years ago and obstinate sciatica two years ago, since which time he thinks he has lost weight. He smokes a good deal and drinks wine in moderation. He now complains of dyspepsia (without vomiting), constipation, dyspnoea, impaired vision and pain in the right shoulder. For at least ten years he has looked pale. Now he looks very pale, sallow and feeble. The tongue is clean, the pulse soft and regular. At the apex, which is in the fifth space in the nipple line, there is a faint systolic murmur, transmitted a short distance to the left. The second sound is accented on the left side of the sternum. No enlargement can be made out to the right. At the base of the lungs, posteriorly, can be heard fine moist rales on full inspiration. The liver is not enlarged. There is moderate tenderness in the left epigastrium. On bimanual examination, a rounded mass can be felt, moving with respiration, about three inches below the right costal border.

The urine contains about $\frac{1}{10}$ per cent. albumen and a few hyaline and granular casts, some of which display a little fat. There are also a few abnormal blood globules in the sediment, and crystals of uric acid. The total amount in twenty-four hours is one quart, with a specific gravity of 1015. The blood shows no leucocytosis. Red cells 1,000,000. The painful shoulder presents no objective peculiarities.

The patient is a man of thirty-five, who has had fever and cough for two weeks. At the beginning of his sickness, had much pain in the front and right side of chest near attachment of diaphragm. Had a chill on two successive days and on the fourth day. No dyspnoea or orthopnoea; no sputa till sixth day, when a scanty, mucopurulent spit began and has steadily increased in amount and grown more purulent since. The fever has ranged from 101 to 104 degrees all through the sickness, and at times there has been a good deal of sweating. Slightly delirious at times. Has taken liquids fairly well. Bowels are rather loose, as they have been off and on for several years. No pain anywhere now.

Physical Examination: Sallow, dull and listless; tongue clean. Poorly nourished. Over lower half of right chest marked dulness, with distant bronchial respiration and increased whisper; voice sounds nasal, especially near angle of scapula. Fremitus nearly absent. Over upper half of lung medium moist rales were heard on the first and third days and none on the second, Physical examination otherwise negative, except slight tenderness and fulness in the abdomen.

Sputa examined for bacilli, none found.

Urine high colored, acid 1027, trace of albumen, no sugar.

Sediment: Abundant urates, leucocytes and squamous cells. Few hyaline and coarse granular casts.

Blood: Red, 4,200,000; white, 26,000; Hb., 43 per cent.

Diagnosis? Prognosis? Treatment?

A clerk, married, twenty-four, is seen the afternoon of January 5. His family and previous history and habits are good. He went to bed the night of the 3d in his usual health and slept well. On rising in the morning he had a severe chill, but went to business. After an hour or two, he was obliged to return home, feeling very weak and aching all over. He took to his bed, raised some bloody sputum, had some nose-bleed and passed urine freely without pain, containing much fresh blood.

When seen he did not look very ill; pulse 100, respiration 24, temperature 103.6. He complained of no pain. Physical examination was negative, except for slight dulness with feeble respiration and crepitus over the left posterior base of the chest.

There were several discrete, viscid, bloody sputa in a cup. The urine was smoky, 1014, with a very large trace of albumen, urea 1.64 per cent.

The sediment contained considerable normal and abnormal blood, rather numerous epithelial casts of large diameter, one disintegrated blood cast; one or two large, fine granular casts. Leucocytosis present.

A young man of twenty-one is seen January 10. At the age of twelve he had very severe scarlet fever, followed by endocarditis, for the results of which he was under medical care for about three years. Of recent years his health has been very good and he has ridden the wheel fast and far without inconvenience. Rather more than two months ago he went to the doctor's office with a "cold," temperature normal. A few days later he returned with a temperature of 103 degrees, and said he had had night sweats. He was sent home, sat about the house for two days and then took to his bed, which he has not left since. A four-hourly chart has been kept for sixty-two days, and shows a continuous fever, ranging from 101 to 104, usually higher in the afternoon. On the seventh and tenth days after taking to his bed he had nose-bleed. This he had occasionally when well. Cough has been a fairly constant though not prominent symptom, and twice has led to vomiting. The bowels have been regular with the aid of an occasional enema. Delirium has been practically absent. Early in his illness there were a few doubtful rose spots. The spleen has never been palpable. He has once or twice complained of some pain in his shoulders, but has had no other articular symptoms.

The pulse was about 90 at first, regular, of good strength. It has lately become irregular and rapid, some of the heart-beats not reaching the wrist. Under digitalis, brandy and strychnia, the pulse has improved very much and is now regular, 100. Ever since he took to his bed he has been on an exclusive milk diet. The urine is sufficient in quantity with a large trace of albumen, granular and hyaline casts, specific gravity 1015.

The patient is pale, lies on his back, has a clear tongue, complains only of weakness.

On physical examination the lungs seem clear. The heart's impulse is in the fifth space, half an inch to the left of the nipple. A systolic murmur is heard at a maximum intensity over the impulse, transmitted into the axilla. Inside the left nipple is a doubtful presystolic murmur. The pulmonic second sound is accentuated, aortic second sound clear. The belly is slightly distended, duller at the flanks than in the centre, the dulness and resonance shifting somewhat with change of position. The blood shows a moderate leucocytosis and no Widal reaction.

Diagnosis? Prognosis? Treatment?

A girl of nineteen is seen May 26. Her maternal grandfather died of phthisis. Family history otherwise good. She has always been rather pale and delicate, but had no definite or serious illness. Toward the end of February she consulted her physician for slight swelling of the glands on the left side of the neck. The temperature was slightly elevated when taken after this, and during the next two weeks the glands increased considerably in size and she had some cough, apparently due to bronchitis. Toward the end of March she began to improve and the glandular swelling to subside. The appetite increased and she got out. Two weeks ago she was less well; fever returned to a moderate degree, as did cough, and slight crepitus was heard under both clavicles. One week ago, the day being mild, she sat on the door-step and experienced a sudden pain at the root of the nose, just between the eyes. This pain extended over the forehead, increased in intensity and was relieved more by cold than by hot applications. Four days ago without obvious cause she vomited once. The next day she vomited again and the headache became intense. For the past forty-eight hours she has retained nothing on her stomach. To-day, there was slight hiccough after vomiting and the menses appeared, the first time for three months. Morphia by the mouth gave her no relief. In the last twelve hours she has had three suppositories containing a quarter of a grain of morphia each, with only partial relief to her headache. Before the morphia was begun the pupils were large, equal and reacted equally to light. Her aunt states that the pupils have always been large. They are now moderately contracted, equal and respondent. Photophobia. The pulse has ranged 90 to 100. Temperature 99 degrees this morning, 100 last night.

The pulse is now 60 to 100, changing its rate quickly and frequently. Respiration easy. The mind seems clear, but she is very disinclined to talk or make any effort.

The glands in the right side of the neck are slightly enlarged. The heart is negative. No rales are detected over the fronts. The backs are not examined as it does not seem wise to disturb her to that extent. Abdominal examination gives negative results. The reflexes, superficial and deep, are not obtained. Urine negative. Neither the sputum nor the blood have been examined. There is no paralysis.

Diagnosis. Prognosis. Treatment.

A lady, sixty-three years old, had serious spinal trouble when a girl, which has left an angular projection in the lumbar region. Otherwise she has always enjoyed good health. Her catamenia ceased eighteen years ago. Her present illness dates from three months ago. Not feeling quite so vigorous as usual, she had gone into the country for a change, when she was prostrated with nausea and vomiting, although unable to think of any especial error in diet.

Since that time she has become decidedly feeble, so that she spends much of the day time on a lounge. Occasionally she takes a short drive. Her appetite is much impaired. Her digestion is capricious; vomiting may occur after eating and also without relation to meals. Sometimes there is diarrhoea. There is no pain, except some headache, in the vertex. There are alarming attacks of dizziness and faintness which seem to be getting worse. She has never lost consciousness. The patient calls attention to a brownish pigmentation which has recently appeared on the backs of her hands and on the knuckles, and which is confined to these places. The face is pale, but with a muddy rather than a transparent complexion. The tongue is not remarkable.

The heart is feeble, but not enlarged nor displaced. The lungs and abdomen are negative. The urine is normal. The blood shows a moderate anaemia. The vomitus contains free hydrochloric acid.

Diagnosis? Prognosis? Treatment?

A well-developed and fairly well-nourished man, eighteen years old, is seen for the first time February 26. His father died of consumption, his mother of rheumatism and heart disease. He has never drunk steadily, though occasionally to excess. He chews five cents' worth of tobacco and smokes twenty cigarettes daily. For eighteen months, ending seven months ago, he had almost daily coitus. For the last six months he has had gonorrhoea. When a child he had diphtheria, at fourteen typhoid, for the past seven months pain in the epigastrium, on rising, and latterly some pains about the head. Ten days ago, when he tried to get up, he had vertigo, chilliness, sweating and a feeling of unsteadiness. He has been in bed most of the time since.

The symptoms were: weakness, backache, epigastric pain (without nausea or vomiting), cough with whitish expectoration, thirst, headache and constipation. His chief complaint now is weakness, next to that headache and dizziness. There is some dyspnoea, but the cough is not troublesome. There has been no nosebleed. The patient is pale. His pupils are equal and react to light. The tongue is protruded promptly and in a straight line, is not particularly tremulous and bears a slight white coat. Both sides of the chest move equally; there are no areas of marked dulness or of increased vocal resonance or bronchial breathing. A few coarse moist rales are heard at the right apex. The heart's apex is in the fourth space in the nipple line. There is no murmur nor enlargement. The pectoral muscle contracts when percussed. The skin flushes easily. The abdomen is enlarged, tympanitic, not tender. There is gurgling in the right iliac fossa. The spleen cannot be felt; its area is tympanitic. The hepatic area is normal. There are no rose spots. The knee jerks are lively. A few glands are felt in the left side of the neck, and on the right side is a scar. The white cells number 3,600. Temperature 101 degrees, pulse 80, respirations 25. The urine has a slight trace of albumen, with a sediment containing pus and squamous epithelium. No diazo reaction is present. No tubercle bacilli are found in the sputum.

During the next five days the temperature is irregular, varying between 99 degrees and 103 degrees. The pulse gradually falls to 70. The respirations rise slightly, to 30. On March 1st

a faint diazo reaction is obtained. The headache ceases after February 29th. The mental dulness deepens to stupor. Constipation persists. On March 2d the physical examination is the same as on February 26th. On March 3d there are involuntary micturition, difficulty in swallowing, Cheyne-Stokes respiration and external strabismus. Nothing peculiar is noticed about the neck. The arms are at times rigid and contracted. There is ankle-clonus.

Diagnosis? Prognosis? Treatment?

A gentleman of eighty-two is seen April 17th. He has always enjoyed good health, except for a period a number of years ago, during which he suffered from attacks of pain in the right upper abdomen, diagnosed as bilious colic, and for which he kept morphine constantly on hand. During the past year he has seemed to age more than previously, but he attended to business regularly until the middle of March, when painless jaundice came on and rapidly deepened, the stools being clay-colored. A week ago the jaundice seemed less and some color was seen in the dejections, but this was only temporary. The appetite and digestion have been fair; he smokes a good deal. He has been dressed and about the house until to-day, when increasing weakness induced him to remain in bed. Pruritus has interfered much with sleep. The temperature has been normal until to-day, when 100 degrees was registered. The pulse has been regular, about 70; yesterday it was irregular and intermittent.

At the time of the examination he was sleeping in the right dorsal decubitus, with easy respiration; pulse 68, regular, of fair strength and volume. Icterus intense, the tongue heavily coated and dirty, the mind clear.

Thoracic examination gave negative results, except for slight crepitus at the right posterior base. A smooth edge could be felt below the right costal border, descending with inspiration, not tender. The gall bladder could not be felt. Abdomen soft, otherwise negative. Urine sufficient in amount, 1018 in specific gravity, deeply icteric, with a trace of albumen, hyaline and granular casts.

Diagnosis? Prognosis? Treatment?

Summary

1 Acute abd. ± vomiting
2. Diarrhea
3 Fever + Pulse +
4 neurotic Element
5 Cough and râles

Diagnoses

? 1. V.D. { General ? / Intestinal ✗ / Peritoneum ✗
2. Typhoid
✗ 3. Gastro-int. catarrosis ± diarrhea
✗? 4 ~~Dysentery~~
✗ 5 ~~Malaria~~
✗ 6 ~~Influenza~~
✗ 7 ~~Malig. Endocard.~~
✗ 8 ~~Pelvic Perit.~~
1/2 9 ~~Bronchitis~~
✗ 10 ~~Subacute hepb.~~

Bronchitis certainly exists but not acct for all the symp.
Not 10 because too much fever, no edema, no urine symp.
8 no evidence as tenderness, pain or in pelvic.
7 chills always + sweats. W.B.C. + Bl. culture pos.! Must consider, but unlikely.
6 Very sudden onset, fever short.
5 Chills, Splen +, Bl. exam.
4 No evidence why rules it out except bl. exam. Might very well be caused by Schegio bug.
3 Temp. too high + too prolonged for neurosis.
2. Nothing to rule out T.B. and nothing to confirm it except for peri. & must have fluid in glands, omental tumor.
Intestinal T.B. goes ± V.B. of lungs or larynx. No evidence of it here.
If T.B. exists it is localized but then are not enough symp. for this.
2 Must be Typhoid because nothing else to account for the fever + symp.

7/19/04 February 16th a married lady of thirty is seen in consultation. During the eight years of her married life she has had four children, the youngest four months old. After her second confinement had puerperal septicæmia, and the catheter was used for some time. Cystitis apparently followed, as irrigation of the bladder was practised. Vesical symptoms were troublesome after this, and five separate times she underwent prolonged treatment under an eminent gynæcologist. Finally, discouraged by the persistence of her symptoms, she resorted to the "mind cure," with marked relief. During her last pregnancy she was unusually well and her confinement was easy, but was followed by a return of vesical symptoms. For the last five or six weeks she has suffered from more or less indigestion and has had frequent watery stools, preceded by abdominal pain. January 23d she came to Boston, hoping to be benefited by the change; and, acting on the advice of her "mind cure" friend, shopped, went to the theatre and was generally very active. During this treatment she ate scarcely anything, and at the end of five days, returned home. The next day vomiting appeared, and by February 1st, when she called her physician, the stomach retained nothing. The vomiting ceased within two days and has not since recurred. The bowels have continued loose, moving two to five times daily without notable pain. For two weeks there has been some cough, with little or no expectoration. Since her physician was called, pyrexia has been constant, — as a rule, higher at night, though sometimes higher in the morning, ranging broadly between 101 degrees and 104 degrees. The pulse has ranged between 110 and 140. No delirium.

The hands are cold and clammy, the color of the face is good, the eye bright, the mind clear, the knee jerks lively. The chest and abdomen are negative, except that some medium rales are heard at both bases, and there is some tenderness along the colon and in both flanks. The urine is said to be negative. It is stated that she is a very reticent person and has never been known to be hysterical.

Diagnosis? Prognosis? Treatment?

1. Tabes ?
2 ~~G.P.~~ S.P. ?
3. Cirrhosis ?
4 ~~Chr. Bronchitis~~ ?
5 D.T. ?
6. Arteriosclerosis ?
7 ~~Sciatica~~ ?
8 ~~Syphilis~~ ?
9 Chr. Neuritis ?

} Alcoholism

11/17/04.

A contractor of fifty served in the navy through the civil war and has been a very active and successful man. He is of heavy build, stout and red in the face. For several years he has had violent cough in the winter, accompanied by vomiting, and he went to Bermuda two winters in succession, with benefit. A daughter of sixteen some years ago ran off with a man and got married. He took to his bed, cursed, cried, called for his pistols and was going to kill the husband, but he calmed down soon and the young people were sent for. His physician thinks he does not use alcohol in notable excess. Two weeks ago, he began to complain of tearing and cutting pains in his legs, accompanied by slight oedema, and for several days now he has been in his bed. Fever has been absent. There has been some vomiting, not specially characteristic in any way. Mental excitement has been a prominent symptom; he has threatened to kill all Democrats. Sleep has been poor. The pains in the legs have continued, but less severely since he took to bed.

The pulse is 80, regular, the tongue heavily coated, thorax negative. The edge of the liver can be felt two inches below the costal border, apparently smooth of surface. Motion and tactile sensibility in the legs seem normal, but the leg muscles are tender when firmly handled and the knee jerks are very slight, even on reinforcement. The urine is reported as negative.

Diagnosis? Prognosis? Treatment?

~~S~~. a drug. } Alcoholism covers all symp.
such as + Liver, pains, mental state, & sclerosis.

Eosinophilia { Trichinosis
Skin Diseases (Bullous)
Asthma
Animal Parasites of Guts (Uncinaria)

Prognosis Will live for some time probably.
Duration long. Recovery good if can cut off
all alc. Nutrition will get well. If liver is
fatty & will get rid of it. If cirrhosis not.
6 mos ± before gets over neurites.
No relapses if lets alc. alone.

℞ Red. Diuresis.
For pain – Local heat – or cold.
Mustard Leaf
Electricity { Faradism
Galvanism
High frequency

Cupping
Cautery

Run Coal Tar products. If all these fail
try Opiates.

Physician, fifty-one years old. Rheumatism off and on since childhood, but no cardiac symptoms; has walked a great deal and has done a large practice without a carriage. November 17th, began to have chills and sweating at irregular intervals, but kept at work until December 27th, when he had sudden pain in the left leg, followed by some coldness and numbness.

Since December 30th, there has been fever from 99.5 degrees to 103 degrees, with irregular chills. Few days ago, seized with pain in right arm, and the pulse was not to be felt in that wrist. Also a transitory blindness in right eye. Great tenderness over right carotid. Pulse 72, regular, good strength. Presystolic murmur at apex. Arms and legs now warm. The patient is bright and not feeling very sick. Spleen slightly enlarged, palpable, tender. Some doubtful rose spots. A right base behind a patch size of an apple of bronchial breathing and crackling rales. No distinct rales. Voice sounds increased over same area.

Urine negative.

Diagnosis? Prognosis? Treatment?

Male, fifty-six years old, real estate agent, formerly painter. Family history negative. Gave up painting six years ago; health not good. Had worked hard. Habits good, denies venereal. For one year, following exertion, he has had pain extending across chest, never into arms, with dyspnoea. No cyanosis. Cannot walk three blocks, even slowly. Dyspnoea never wakes him from sleep. Consulted a physician, who prescribed apparently for stomach, without relief. Has gained weight in past year. No gastric symptoms.

Examination: Pulse 52, regular, except one intermittance. Apex not visible or palpable. Sounds clear when standing. When lying, a slight systolic, aortic murmur. Cardiac dulness extends to left nipple, not increased to right. Second sounds rather weak; otherwise, negative. Urine, 1022; no albumen.

Diagnosis? Prognosis? Treatment?

Man, fifty years old, a hard drinker, except during the past year. No family history obtained. For two or three years he has had pain after taking food, occasional vomiting and progressive loss of flesh and strength. For the past eight or ten weeks he has complained of frequent and severe pain of a "stretching" character in the right hypochondrium, but without much tenderness there. For the last two weeks he has been deeply jaundiced. He has been confined to bed for a week and is much emaciated and prostrated. His nights are much disturbed by pain. The liver is greatly enlarged, hard, irregular and nodulated, the lower edge reaching to the anterior spine of the ilium; it also extends to the left of the median line about two inches. It is slightly tender. There is little or no ascites. Pulse 92; temperature 98.5. Urine rather scanty and very dark. No itching of skin.

Diagnosis? Prognosis? Treatment?

1. Appendicitis ?
2. Acute Gastritis ?
3. Catarrhal jaundice ?
4. Influenza
5. Typhoid ✗
6. Colitis ✗
7. Perityphlitis ✗
8. Ac. Pancreatitis ✗
9 Gall Stones ✗
10 Gastric ulcer ✗
11 Cholecystitis ✗
12 Mesenteric Infarction ✗

11/17/04

Dentist, forty-two years old, always well until within four days, when, after a hard day's work, was taken at night with a chill, vomiting and epigastric pain. Temperature 102 degrees. Next day, temperature 99.4 degrees, but vomiting continues and was so exhausting that a morphia subcut. ¼ gr. was given. Pain not so severe as the night before, but considerable epigastric tenderness. Kept his bed. Temperature 101.4 degrees in afternoon.

On the third day, the one previous to that on which I saw him, the vomiting was less persistent and temperature a little lower, but he felt very weak and faint, wanted no light or sound in his room and desired to be left alone and not disturbed. Slight tenderness over the whole abdomen now developed, with perhaps a little more on the right iliac region. Bowels have been moved freely by cathartics each day. To-day, feels as if there was a mass in the rectum. Urine very scanty in the last three days. Was examined a week ago and found normal. There has been no oedema. Has been working very hard of late.

Examination: Tongue clean; temperature 99.2 at 8 P. M.; pulse 68, good strength. The patient is pale, and looks exhausted and in pain. Thorax negative. Slight general abdominal tenderness, not localized, but slightly greater in the epigastrium. No enlarged glands. Rectal examination negative.

Diagnosis? Prognosis? Treatment?

Cancer of Rectum - patient not conscious of any mass there.
Scant urine { Vomiting / Temp. / No injection of fluid / Cathartics

Temp. of 99.2 on 4th day rules out Typh.
In gastric ulcer get temp. & { Perforation / Future Hemorrhage
Tenderness is + in more localized.
If + w.b.c. exclude 3 + 1.
" — " " " 2 - 11 - 1.
No symp. of all of Colitis.
no symp. of Cat. Imm. appeared till later.
Fluid diag. must not be drawn —
{ Acute Gastric Indig.
{ Influenza
{ Gall Stones.

In giving a Prog. state average figures of mortality, duration, recurrence & after health. Then state likelihood of above in this case.

In this case recovery delayed by overwork & by excess purging.

℞. liquids, stop cathartics, Bismuth Subnit.
℞ Proctitis - enema of ℥ii cooked starch. Ev. 4 hrs. relieved.
No occ. for change here. Keep on milk diet till he gets hungry for more solid food.
In giving milk avoid giving it ice cold & take a spoon slowly.

Barkeeper, thirty-four years old, hard drinker, thinks he had a chancre some years ago. No secondary symptoms noted. Has been well till three months before, when he began to have sharp pains in top and front of head, also some dimness in left eye. During this time frequent nausea and vomiting. When first seen, his vomiting had diminished under careful diet. Temperature 99; pulse 104, rather strong and incompressible, but rapid at times. Heart's dulness a little outside the nipple. Sounds weak but clear; considerable praecordial pain, at times running round towards the back. Palpitation.

Soon after this, the patient had several attacks of pain in the right back shooting to the groin. During and after these, he passed a great deal of blood in the urine and some whitish soft masses.

Urine contained $\frac{1}{8}$ per cent. albumen. The sediment, mostly pus and blood, obscuring whatever else may have been present.

The patient was seen one Sunday, no worse than usual. Next day, felt unusually well till afternoon when he became hemiplegic, comatose, and died.

Diagnosis? Treatment?

A woman, apparently about forty, seen at hotel at 6 P. M., unconscious. Semi-dilated pupils, equal and responding to very strong light stimulus. The face is pale; pulse 90, regular, small and soft. Respiration is shallow, with an occasional deep inspiration. Temperature normal. No blood or froth on lips; no odor to breath. No disparity between sides of face. Limbs flaccid, but firm supraorbital pressure causes motion in one or another extremity, so also firm pinching of leg muscles. No reflexes, deep or superficial; no oedema; no glands. Old, white, irregular scars seen near root of nose, on forehead and right cheek. Physical examination of thorax and abdomen negative. Urine by catheter, 1017, acid, no albumen, no sugar.

In the absence of all friends, the housekeeper states that the patient and her husband came there from a neighboring town the evening before. The husband was awakened in the night by some noise to find his wife unconscious. Later, she vomited, but had no convulsion as far as known.

Diagnosis? Prognosis? Treatment?

A child, seven years of age, of healthy parentage, had made frequent complaint of pain in the left side of abdomen and was found by her mother to be rapidly losing flesh and strength. There was also an account of quite frequent voiding of high-colored urine, with a brownish sediment.

After several weeks, the emaciation progressing, the mother noticed that the left side of the abdomen was larger than the right; that there was pain and tenderness on pressure, and that periods of "constipation" occurred, followed by the escape of large quantities of semi-liquid faeces, without much change in the size of abdomen or relief to the pain and tenderness in left lumbar region.

About this time the patient was taken to a physician, who confirmed the mother's observation of loss of flesh and strength, for the child was pale or sallow, emaciated and extremely weak. In the left lumbar region a mass, irregular in outline and surface, painful on palpation, extended into the umbilical region and upwards to the margin of ribs in front; percussion showed tympanitic resonance over the central portion of the tumor. Elsewhere the tumor was flat on percussion.

A specimen of urine showed: Reaction, acid; Sp. Gr. 1014; sediment, brownish and consisting of blood and brown granular matter; there were no casts, and the quantity of albumen present was small.

Diagnosis? Prognosis? Treatment?

A woman of thirty-five, married ten years, five children. Has had considerable womb trouble and been treated for it by local physician. Of late, it has been less troublesome. Father died of cancer, mother of "a decline." For a year has had much to worry her, and has been running down and getting nervous. Is troubled with sour eructations after meals, especially in the morning. Bowels rather costive. Appetite as good as usual. Lost no flesh. Occasional severe headache, frontal and occipital. Sleeps poorly. "Hot flushes" frequent. For the last day or two (since coming to Boston) vomiting a good deal greenish stuff.

When seen, was drawn and pinched in the face and nauseated. Complained of general abdominal pain, but no tenderness could be found, and physical examination was negative except a sharply accented aortid 2d sound. At times quite hysterical, after which she passed a large amount of pale urine. Very nervous, restless, and alarmed about herself. No fever; pulse 110. Complained at times of headache. Knee jerks increased; no clonus. Uterus retroflexed and bound down with adhesions.

Diagnosis? Prognosis? Treatment?

Man, sixty-six years old, has been complaining for fifteen months of pain which was for the first month or two referred to the region of the right hip and buttock. Later, the pain was felt also in the small of the back and in both scapular regions; for the last six months, pain has been felt in the other hip as well. Pain occasionally shoots into the legs, but is generally confined to the back.

For a month or two has been having considerable cough, with white or yellow sputum, occasionally streaked with blood. He has always been finicky about his food, but complained of no special digestive disturbance, except loss of appetite and constipation, which have been continuous through his illness and have been accompanied by considerable loss of flesh. Used to be very fat before the beginning of this illness. Of late has had several attacks of retention of urine, which needed catherization.

Examination: Rather spare, but by no means emaciated; arcus senilis well marked. Heart negative. Scattered patches of rales in both backs and in the right axilla. Abdomen negative. Knee jerks normal; no tenderness or loss of sensation. Spine straight and not tender.

Urine 1016, alkaline, trace of albumen, considerable pus and squamous cells.

Temperature 99, pulse 90, respiration 22.

Diagnosis? Prognosis? Treatment?

J. B., male, aged thirty-two (occupation, cook), came to the out-patient department of the hospital January 6, 1899, complaining of pains in the body and limbs, accompanied by fever. His family history was negative and previous history good, giving no history of syphilis; he admitted, however, having had a urethritis some years previously. He had never had an attack similar in character to this. The present illness he dated from December 30, 1898, eight days before applying for relief at the hospital. The first symptoms seemed to have come on rather suddenly with a rigor of marked severity, followed by fever and, later, by profuse sweating. Almost immediately afterward he was seized with intense muscular pains, extending over the trunk and limbs; these pains were agonizing in character, increased on the slightest exertion and had been present, with varying degrees of severity, until his admission. They prevented him sleeping, and were spoken of by the patient as being not unlike rheumatism, *i. e.*, dull and aching, while he was in the recumbent posture, becoming intensely lancinating as soon as the slightest exercise was attempted. His appetite, which had previously been of the best, was absolutely lost and he had eaten nothing for three days. With the exception of some slight frequency of micturition and a slight cough, with expectoration, there was nothing else of importance in the history of the illness.

Examination: The patient is rather a large, well-formed man, the mucous membranes of good color, tongue moist and with a slight white fur. The eyes are markedly injected, the eyelids slightly but distinctly edematous and an erythematous area above the swelling. Negative results were everywhere on auscultation and percussion, except at the bases of both lungs behind, where a few moist rales were made out. The heart sounds were quite clear. The liver and spleen were not palpable; the abdomen was soft and natural in appearance, negative results being obtained on palpation. No rose spots were seen. There was no superficial glandular enlargement. Pulse was 100, respiration 24 to the minute, temperature 103 degrees. The urine was normal in color, acid, specific gravity 1026. Microscopically, it showed pus-corpuscles in considerable quantity, epithelial cells and a few mucus cylinders.

Diagnosis? Prognosis? Treatment?

A middle-aged woman "took cold" on Saturday and was afterward distressed for breath. She was seen on Tuesday evening sitting up, breathing with some difficulty and with a wheeze, chiefly with expiration. The face was red but not livid. She complained of pain at the top of the sternum and side of the throat. There was expectoration of white frothy mucous and some tough brown masses. The voice was suppressed. The tonsils were not swollen, there was no exudation in the pharynx, and the epiglottis was not swollen. The pulse was rapid. The physical signs were negative with the exception of prolonged expiration.

Diagnosis? Prognosis? Treatment?

A female domestic, twenty-nine years old, single, lost her father, a dissipated man, from phthisis. Her family history is otherwise negative. She herself has never been very strong, was chlorotic for a time five years ago, but has never had any serious illness. A year ago, before coming to this country, she took a very severe cold, and a few days thereafter experienced a sudden and intense pain in the left lower axillary region. This pain was accompanied and followed by cough, with little or no expectoration. She was not long laid up, but has been short of breath on exertion ever since. She denies persistent cough, and states that it is present only when she takes cold; expectoration at these times is scanty, but several times has been blood-streaked. She thinks she has lost no flesh and has not been feverish. She has been and is now steadily at work. Her employer sends her to be looked at while the physician is visiting a member of the family.

The general appearance is that of health. The pulse and temperature are normal. She complains only of shortness of breath, especially when mounting stairs, dry cough, and inappetence. The chest is well-formed and symmetrical; the interspaces are equally defined on the two sides; no cardiac impulse is visible; the left chest dilates less than the right on full inspiration. The heart sounds are loudest, and the impulse can be best felt, just below the ensiform cartilage; the sounds are normal. The cardiac dulness seems to extend farther than usual to the right of the sternum. The right chest is hyperresonant throughout, with puerile respiration. Percussion is tympanitic all over the left chest, including the cardiac area, with very feeble respiration and absence of vocal fremitus. In the left lower axilla and under the breast there is a faint, amphoric breathing.

Diagnosis? Prognosis? Treatment?

Numbness - if central mid - be motor disturbance r on lt. side. Probably local injury -

Temp. Due to: 1 "grippe"
2 Concussion
3 Compression
4 Constipation multiple
5 D.T mid-heart blemur

In any case of typhoid fever always consider typhoid as a poss! cause.

In this case the Widal was + & the disease ran a typical course. Typhoid often runs a course like this & no symp. but a temp. a typhoidal condition.

This might resemble malaria & also remittent fever continuous fever.

Skin also consider some exanthem in ev. case of fever before skin rash has come. Also think of malignant endocard. in cases of blind fever & no symp. Also infant G.I.

Syphilis also to be regarded.

Paratyphoid is to be considered. Runs same course & some symp. except have no Widal. Get clumping & culture of paratyphoid bugs. Rx same as for typhoid

Prog. life good. Nurse for 6-8 weeks. Return to work in 12 to 16 mos ± likely to relapse but likely never to clear. Will be better in health after it.

Rx - Milk + lime water or buttermilk. Butter makes less tough curd. Give 6-8 oz ev. 2°.

Shattuck's Diet - Feed acidity to diminish. Start & liquids. Experiment & liquids & soft solids till get some idea. Then return to liquids & change & to the soft eggs, chopped meat, soft toast, &c.

Liquids are gruels, beef juice, koumyss, broths, albumin water.

Empty bowels & below rather than above. Enemas useless to clear out bugs, because they are in blood &c.

Baths for cleanliness, to reduce fever, make comfortable & give sleep. Prevents hypostatic cong. by deep breathing. Cool bath in perforation & hemorrhage.

During bath pulse is very poor but tension is good. The bath contracts & strengthens the walls of arteries.

Start & bath 80-90° & keep it so no matter what the temp. Keep in bath for 15-20 mins.

Don't wake to bathe or sleep, feed unless sleeping all the time. Enemata eo. 2nd day. Constip. more common than diarrhea in typhoid. No drugs except for special symptoms.

Results show that no stimulation in Typhoid is needless. Ale, whisky, or digitalis needless. Ca. 1/2 cases need no tonic or no one spirits. Adrenalin might be good.

Typhoid Fever.

11/12/04 A stock broker of twenty-six, of moderately alcoholic habits, but with no venereal history. Has always been well. Been under a surgeon's care for last three days for "grippe" and taken whiskey and ammonol. On the third day, Saturday, he took two whiskies and then went to ride on horseback. The horse shied and threw him. His head struck on a rock, the blow affecting the region just above and in front of the right parietal eminence. He was unconscious for ten minutes, and after being carried home he vomited and complained of pain in the occipital region. There was numbness of the right hand. The temperature was 104 degrees, the pulse 90. Next day it was 103 degrees in the morning and 103.8 degrees in the evening. Monday it was 102 degrees with a pulse of 85. There has been no movement of the bowels. Patient has fully regained consciousness, but is still somewhat dazed and dull. There is no evidence of fracture or suppuration anywhere, but there is numbness along the ulnar side of the right hand.

Seen in consultation Tuesday, very bright and energetic, sat up strongly in bed to shake hands. Laughed and talked, wants to get up, but temperature still 102.

Diagnosis? Prognosis? Treatment?

A rather nervous gentleman, forty-three old, both of whose parents died of cancer, married about a year before his present illness began. About the same time he moved from the city to the country and became quite active out doors, with benefit to his appetite and general health. The winter snows, however, forced him to be more sedentary. When first seen in consultation with the family physician, who had been called only four days before, he complained of obstinate constipation. For six weeks he had had darting pains in the lower abdomen, worse at night, but relieved by walking. For two weeks he had been constipated. The physician had first prescribed a mild laxative pill, which caused some griping but no dejection. The next night he sat bending forward in pain most of the night, getting relief from an hypodermic of one-quarter grain of morphia, twice repeated, which was followed by a fæcal discharge. At that time the bowels were soft, except for resistance corresponding to the ascending, and particularly the transverse, colon. The next night he had an ounce each of glycerine and castor oil, but was rather worse the following day. Some flatus escaped on the day of the consultation, but no fæcal matter had come away for at least four days. The temperature had remained normal. There was no vomiting.

Physical examination showed a spare man of middle age with a somewhat anxious face. Rectal examination was negative. The abdomen was distended with gas and somewhat tense, but nowhere especially tender. When the patient's attention was diverted, the same resistance could be felt which has been already described. The pulse was not remarkable at first. After the examination was concluded, however, it became much more rapid and feeble, but improved again after a little brandy.

Diagnosis? Prognosis? Treatment?

Single lady, fifty-seven years old, always more or less of a nervous invalid, consults a physician for palpitation and dyspnoea on exertion. The menopause occurred five years ago, and since then she has been getting very stout and disinclined to exertion. She is thirsty and her skin is dry and perspires very little. Of late, the feet have been swelling and her face seems puffy all the time, not especially under the eyes. She is troubled a great deal with headaches, worse at nights, and her hair has been coming out of late. No sore throat. The bowels are very costive, appetite capricious, sleep disturbed by headache. Her memory is very poor and she takes little interest in anything.

Physical Examination: Heart's area cannot be marked out on account of the great thickness of the fat layer. The apex is not seen or felt. Best heard in sixth space, one inch outside nipple. Sounds heard feebly, action irregular. Pulmonic second plus; no murmur. Lungs and abdomen negative. Temperature 97.8 degrees, pulse 100. Urine 1018, acid, large trace of albumen, no sugar. Amount, two quarts. Sediment: hyaline, granular casts, small diameter, some with renal cells adherent. Blood: red, 6,000,000; white, 12,000. Oedema of ankles. Hands and feet cold.

Diagnosis? Prognosis? Treatment?

morphine withheld here because in former yrs. the man had been a morphine eater. This might have caused the pain.

II 26 '04

Tabes.

A middle-aged man was seen writhing in intense pain referred to the epigastrium. Vomiting of greenish fluid took place; there were loose discharges from the bowels, small in amount. This state of things lasted, with only short remissions for two days, until a small dose of morphia (which, for special reasons, had been hitherto withheld though asked for) was administered, after which there was complete relief for many days. The pupils were dilated, the pulse regular and of normal character. Nothing special had been eaten or drunk to cause irritation of the stomach. The abdominal walls were neither distended nor retracted, no intra-abdominal tumor was to be detected, nor was there excessive tenderness on pressure. It was afterwards learned that he had had several such attacks, that for many months or years his legs had been weak, that he had had neuralgia and numbness in them.

What further examinations should be made?

What was the nature of the acute attack?

Exam. Pupils
K-J. + ankles
Urine
Stools
Vomitus.
Blood
Romberg's
Sail-
arteries

Acute Attack — Gastric crisis (Tabes)
Lead Colic

Consider — morphine poison
Diet'ls crisis

Gastric Pain suggests

Tabes
Lead
Ordinary stomach-ache
Malaria
Gall Stones
Ulcer
Pancreatitis
Diaphragmatic crisis
Cirrhosis
Appendicitis
Ovarian cyst & twisted pedicle
Strangulated Hernia

Summary -

Clergyman, weak eyes, sore throat, indef. gastric symp, paraesthesia.

Must consider Angina Pectoris
Arteriosclerosis
Tabes
Syphilis

Against any org. dis. is fact that man is getting better instead o. worse & because he is at rest enough.

Prog. life good. Recurrence likely. Duration 6 mos.

℞. Remove all source of mental or physical fatigue esp. at night. Never work on empty stomach or at night. 6 meals a day. Warm bath at night for sleeplessness. Cold sponge in a.m. Outdoor exercise.

The ℞ given at the sanatarium was just such as to favor an attack of this sort. He was exhausted already and the ℞ exhausted him still more.

The attack was probably cerebral anemia fr. emot. exhaustion. Hem. ruled out by absence of focal symptoms, by quick recovery & by low bl. press. brought on by the ℞.

Psychical Epilepsy is longer shorter in duration & there would be attacks before & since.

Meniere vertigo lasts only few minutes or hours.

Neurasthenia & attack of cerebral anemia. Gastric attacks due to + acidity dependent on neurasthenia.

A clergyman, sixty years old, of great intellectual power, gave the following account of his case. No cerebral symptoms except sleeplessness, to which he has been subject since he began to preach, but it is under his control unless he is excited by mental labor, the effects of which are most marked when it occupies the evening. Eyes weak for forty years, but no worse of late; can't use them in the evening. Though the voice is clear, its use in lecturing or preaching is at times, when he is debilitated, somewhat painful and requires much exertion. Appetite good, but two to three hours after eating has a kind of epigastric pain or feeling of heat, not dependent on amount or character of food, unless it be worse when he eats little. Ice water seems to touch a raw spot. Bowels constipated since early childhood. Muscular strength good. For many years has been troubled by a sensation over the whole body as if pricked by innumerable needles, and this returns from time to time when he is debilitated.

Four years ago, while much exhausted by mental labor, went to a watering place, where he was put on low diet, reducing remedies and frequent baths. At the end of four months, while at breakfast, was attacked with vertigo and began to talk with great volubility but incoherently. For three days, which were a blank to him, his condition excited much alarm, but at the end of that time his mind became clear and there has been no return of symptoms since. Numbness of hands and feet at time of attack, and of feet occasionally now when exhausted, accompanied perhaps by prickling or a feeling as if cold.

Within two past years has had five attacks of pain in upper abdomen, without known cause, very severe and accompanied by distention and general perspiration. One of these came on after conducting an examination four hours long, another after eating hastily. Otherwise no cause known. Pain generally began at 9 P. M. and lasted till midnight. No other symptoms noticed before, during or after the attack of pain.

11/24/04

T. B.

Young salesman, always well till present illness. Family history good. Worked hard last winter and worried. Frequent headaches, indigestion, insomnia. Feeling poorly for several weeks, especially at end of day, but has worked until week ago; since then, on sofa and in bed. Chief complaints, weakness and pain in right chest. Two chills this week; slight, dry cough; no nosebleed. Bowels constipated and appetite poor.

Physical Examination: Fairly nourished, tongue coated, expression bright, no enlarged glands. Heart shows musical systolic murmur at apex, heard in axilla and back; action slightly irregular; no enlargement. Lungs negative, except over seat of pain in side where was heard a harsh sound synchronous with respiration for a few breaths and then not heard again. Abdomen shows dulness in both flanks, which, however, shows little or no shift with change of position. Liver dulness from sixth rib to rib-margin. Splenic area tympanitic; knee jerks lively. Temperature 99-102 degrees, swinging up in P. M. Pulse 100-110. No sputa; urine negative.

Blood Examination; reds, 3,200,000; whites, 4,000; Hb., 40 per cent.

Lively K. J. indicates neurasthenia n. ∴ all statements of patient should be taken ē grain of salt.

Shows that some function of murmurs are unusual and transmitted - characteristics usually ascribed only to org. lesions.

Mitral Regurg - 3 essentials — Murmur, Enlargement, P 2+

T. B. explains the whole case satisfactorily - anemia, pleurisy, dulness in flanks, temp. The dulness in the flanks helps murmur & anything to confirm a diag. of T. B. Not likely because of darkness

Prog. Fair, good chance of recovery.
Duration 2–3 yrs.
Relapse likely

℞ After subsidence pleurisy & temp. has been given a chance to come down send away to favorable climate. Altitude no imp. here – must stay out of doors all the time. Send to South.

For pleurisy – apply flannel must be very tight. Or counter irritation. Then try morphia.

Fever – cold sponges chiefly for comfort.

Constipation – ammon & mild laxatives.

Experiments show that bitters as appetizers act do stimulate gastric juice but effect compares fine just before a meal.

Best cure is

Tannate of Cocaine gr iv t.i.d.

Diagnoses

1. Traumatic neuroses
2. Aneurism
3. Trauma to Pectoral as result.

Moaning & grinding teeth in sleep seen in brain fag.

Aneurism - pain, phys. signs, pulses unequal ↑ older D.
Rarely is trauma sufficient weakened by Syph.

Traumatic neurosis -

Symptoms at synop. came on later with patient time had a chance to think it over. Also the fact that synop. appeared in other parts of body.
The broken sleep, loss of strength, flesh & color all favor it in the neg. p.E.

Prog. For life good. Duration 2 mos ±.
Recurrence likely.

℞ - Secure confidence by doing thorough phys. Exam.
Reiterate this over & over again.

/19/04

A fireman of twenty-six is exercising the engine-horses, riding one and leading another. The led horse falls and, as he struggles to rise, wrenches severely the arm of the fireman, who has not let go the halter. He thought nothing of it at the time, but twenty-four hours later began to be distressed by a sense of weight and pressure beneath the sternum, near the attachment of the wrenched pectoral. Under medical advice he was laid off duty and treated with liniments and counter-irritation, but without relief. A three weeks' vacation in the country benefited him considerably, but on his return to work he found himself unable to drive or even to put on the foot brake without great exhaustion. Now he cannot walk a block fast without feeling completely tired out and experiencing a sense of pressure under the sternum. His wife tells him that he moans and grinds his teeth in his sleep. He has lost flesh, strength and color.

Examination of the chest and belly reveals nothing abnormal.

A young married woman of twenty-one had an abortion done at the third month. Immediately following this she began to vomit occasionally, and after two days could retain nothing. The lochia were sweet, the temperature normal, and there was no tenderness in the pelvis. Rectal alimentation was tried for three days and the vomiting ceased, but recommenced as soon as liquids were given by mouth. Again rectal feeding is tried, but this time the vomiting did not cease. The nutrient enemata are fairly well borne, the nurse says, but the patient is very sleepless and thirsty and has four or five severe retching spells in every twenty-four hours. She is seen in consultation on the sixth day of rectal feeding.

The temperature and pulse are normal, as they have been throughout; the voice clear and the patient moves strongly in bed. Examination of the chest, belly and pelvis are entirely negative.

A negress of sixty-seven has had "falling of the womb" for forty years. Comes entirely outside the vaginal orifice unless supported. To hold it up, she stuffs a wad of cotton into the vagina and ties a tight bandage round the lower part of the abdomen.

Some years ago a lump grew in her belly, — sore as a boil. One night she heard a click, felt something give way and "it all ran out the front passage," after which she felt all right.

Last summer she noticed another lump in her belly, not tender, but sometimes "it kicks just like a baby."

Five days ago she "felt pretty smart," but had had no movement of the bowels for two days. Four days ago the belly began to swell and to be tender in the left groin and to vomit. Three days ago had a small, hard dejection and has vomited no more, but since then "the lump in her belly has been moving round and making a noise." Pain, distension and constipation have continued.

Examination: Temperature 100, pulse 100, respiration 32. Chest negative. Belly much distended, tympanitic and somewhat tender, especially in the left iliac fossa, where there is dulness and a rounded mass size of an orange can be felt. Pressure over this mass causes the cervin uteri to move down. No thorough pelvic examination is possible on account of tenderness.

A shoemaker of twenty-four, who has previously enjoyed perfect health, consults his physician on account of gradually increasing weakness of the legs, which has been noted for six months. He dates the trouble from a fall from a horsecar six months before, when he struck violently upon his knees and fell several times more on his way home. Kept at work till three months ago, when he took a three weeks' vacation in the country and improved considerably; but, on returning to work, found himself unable to do more than half a day's job.

Two months ago the hands and arms began to get weak and numb and now he can't button his collar. The hands feel rather better when he stirs about and uses them. For the past week has felt as if something were tied tightly about his waist.

In other respects he feels perfectly well. He has never used alcohol and denies venereal disease.

Examination: Pupils equal and read normally. Soft systolic murmur at the apex, transmitted two inches to the left. Pulmonic second decidedly louder than aortic. No evidences of cardiac enlargement. Chest and belly otherwise negative. Deep tenderness over calves, thighs and buttocks. Knee jerks absent, muscular power feeble, sensation perfect.

Faradic irritability of the muscles considerably impaired both in the arms and legs. At times the tips of the fingers of both hands sweat profusely.

When seen his temperature was 99.8 degrees, pulse 120, respiration 24.

A man of twenty-nine seen January 29th. Took to bed a week ago with fever. Now he looks very dull and stupid, with lips slightly dusky, tongue dry, brown and cracked, teeth crusted with sordes. Temperature 101.5, pulse 100, respiration 32.

Chest negative. Abdomen slightly distended, tympanitic, not tender. Spleen not felt. There is some twitching of the arms and legs and some tenderness of the latter. All his movements are abnormally alert.

Urine: Normal color, acid, 1020, a trace of albumen, no sugar, no diazo reaction. Sediment, much pus (microscopic) and mucus, a little normal blood, considerable squamous epithelium.

Scattered over the whole body is a macular rash, about the size of a split pea or smaller. In places it is copper-colored.

His chief complaint is of nervousness and insomnia, but he admits that his appetite is very poor and that he has vomited several times within the past week.

A coachman of forty-five, of a very neurotic family, has had dyspepsia for fifteen years. Any worry or excitement brings on distress and sour eructations. Three years ago had a fever called, by his physician, "spinal meningitis;" since then never well in mind or body. Forgetful and bewildered up to the last two months, when he became much clearer and has since devoted himself to his health. There are two spots that always felt hot to him, one over the left kidney and one on the top of his skull. Also numbness on the left leg, less noticed when he is busy. Left hand always colder than the right.

Since the fever three years ago his dyspepsia has been worse. Almost any food distresses him after a time. New foods go well for a short time. If he takes more than one-half a cupful of any liquid he always vomits, and despite his best efforts he vomits very frequently. No blood or brown stuff in vomitus, which consists of food and slime.

Pain and tenderness in epigastrium are almost incessant. Appetite excellent, bowels always costive, sleeps poorly.

Examination: Rather thin, good color, tongue protruded very far. In epigastrium, a resistance uneven, soft and doughy in feel, dull on percussion and very tender. The lower border of it is well defined, especially on the left. At times, movements, apparently peristaltic can be felt there.

Chest and belly otherwise negative. Sensation everywhere normal.

The stomach tube was passed without difficulty and abundance of free hydrochloric acid found in the gastric contents, but the organ would not hold more than six ounces without causing the patient great pain, which lasted for two hours after the tube was removed.

The patient was constantly expectorating saliva, while in the ward and stated that milk always poisoned him, and that the only food that agreed with him is wild game. A partridge was procured for him, but he had a bad night after it, because, as he said, he tasted some of the shot with which the partridge had been killed.

He remained in the hospital from November 1 to November 11, 1892, and then left unimproved. The diagnosis stands "Nervous Dyspepsia."

January 31, 1893, he died, and at autopsy the walls of his

stomach were found to be nearly an inch in thickness — the organ contracted so that it would hold but a few ounces of fluid. A large peptic ulcer was situated near the pyloric end; the pylorus was greatly thickened and enlarged and stenosed, so that it would not admit the little finger.

A business man of twenty-six, of good family history, habits, and previous health, married two weeks ago, is seen late in the evening in November, 1900. In the latter part of July, after golf, which he plays with the left hand down, he suffered during part of the night from severe neuralgic pain throughout the left arm. About a month later he had a second similar attack, not following golf, and the pain then recurred nightly after one A. M. During the day time the pain was only occasional and relatively mild. About eight weeks ago he began to have "indigestion" — *i. e.*, a sensation as if food was arrested on its way to the stomach which, apparently, managed it well enough after its arrival. About two weeks later a dry, harassing cough came on, troubling him most when on his back or right side, was also excited by taking food. Soon after this he noticed that the veins in his neck swelled up when he stooped over. About two weeks ago his neck increased in circumference and he had to have his head higher at night. Lately he has had severe night sweats. Pain, especially in his left arm, dysphagia and dry cough are now the most prominent symptoms. There has been some loss of weight, more of strength.

He is pale, nervous and excited. The temperature is normal, as are the pulse and respiration in the erect position. Lying down causes marked dyspnoea. Toward the root of the neck on the left side discreet, non-tender lumps can be felt, without attachment to or reddening of the skin. Percussion is dull over the upper sternum, without prominence or pulsation. The radials are synchronous and equal in volume; the pupils are equal; there is no tracheal tug. Thoracic and abdominal exploration is otherwise negative. So also the urine. The axillary and inguinal glands are not enlarged. Hb., 70 per cent; reds, 4½ million; whites, 22,300.

A differential count of 500 white cells shows Polymorphonuclear 34 per cent; Lymphocytes 65.2 per cent.; Myelocytes and Eosinophiles, each .4 per cent.

Diagnosis? Prognosis? Treatment?

A married lady, childless, fifty-five years old, of good family history, is seen in February, 1900. She passed the menopause without difficulty, and several years ago had cystitis, with good recovery. During the winter of 1899 she travelled in North Africa, going to Germany toward spring. There her appetite became capricious and she suffered from slight nausea occasionally, without vomiting. She then had an attack of "grippe," which much impaired her strength. In the early summer she returned home, when her appetite and digestion improved much and her strength returned in great measure, though her friends remarked that she was distinctly paler than formerly. She considered herself well enough until five months ago, when she began to suffer from sciatica, at first and more severely in the right side, but later also in the left. About a month later her appetite failed again and more or less constant nausea came on, with occasional vomiting, the latter without relief or definite relation to either the time of taking food or its quality. Then came on very troublesome salivation, leading her constantly to spit up a clear, somewhat frothy fluid, which is sometimes poured out in such quantity as to run from her mouth. This persists to the present time. The sciatic pain now has practically disappeared. She has kept her bed for some weeks, losing flesh (though she is still stout), but sleeping well. Of late there has been slight bleeding from the gums, but no other hemorrhage has been noted.

Pulse 96, regular, soft; temperature 99, above which point it is said not to have risen. Except for marked pallor, physical examination is negative. The urine is negative and contains no arsenic. Several examinations of the gastric contents show neither free HCl nor lactic acid.

An examination of blood slides shows: red cells, 3,000,000 or thereabouts; white, 15,000; Hb., relatively low.

Reds: Rouleaux well formed, deformities slight, no polychromatophilia, average diameter normal, one normoblast.

Whites: Polymorphonuclear, 80 per cent.; lymphocytes, 20 per cent.; eosinophiles, 0 per cent.

Diagnosis? Prognosis? Treatment?

A manufacturer, of fifty-four, of good inheritance and habits, is seen in October, 1898. In childhood he was laid up for a time with what he thinks was rheumatism, and he has since had pains now and then, not laying him up, attributed by him to rheumatism. He has been a very active man and has ridden a wheel. Ten years ago he fell on the ice while skating, striking the back of his head. He was unconscious for a week or two and in bed eleven weeks, but full recovery followed. For the past year he has been less well and strong. Last winter he went to Bermuda, gaining in every way and thirteen pounds in weight. Five weeks ago he drove a pair of pulling horses over forty miles. The next day he had severe pain in his arms, and this has since been his main complaint. The pain extends from the shoulders to the wrists, is worse at night and often requires morphia to secure sleep. Pain and a burning sensation in the fingers comes on suddenly at times, waxes and wanes. He has kept the bed for about four weeks, sending for his doctor first three weeks ago. He has lost some flesh. The bowels are constipated. Of late there has been some general abdominal colicky pain not attributable to laxatives. Fever has been absent. There is no cough or præcordial pain; he lies indifferently on either side with the head low. He is rather pale, with slight icteric hue of the conjunctivæ. The pulse is and has been regular, of fair strength and rather low tension, 96. The tongue is clear and moist, the gums and teeth in good condition.

Tactile sensibility is perfect. There is weakness in the arms and hands, especially in the extensor muscles. This weakness has increased notably in the past week. He can button his undershirt and pick up a pin from a smooth surface, though with difficulty. There is no distortion of the finger joints.

The cardiac impulse is in the fifth space and to the left of the mammillary line. Percussion corresponds with palpation and shows slight extension of dulness on the right of the sternum. In both the mitral and aortic areas soft systolic murmurs are to be heard, one transmitted into the axilla, the other into the neck. The second sounds are clear, the pulmonic sound slightly accentuated. Visceral examination is otherwise negative. Oedema is absent. The knee jerks are obtained, though with difficulty. The urine, 44 ounces in 24 hours, contains neither sugar nor albumen.

Diagnosis? Prognosis? Treatment?

Diff. Diag. { Pleuritic Effusion
Hydro thorax